ORIGINAL ARTICLE
Volume 8 Issue 2 2016
DOI: 10.5959/eimj.v8i2.420
ARTICLE INFO
Submitted: 26-02-2016
Accepted: 10-04-2016

Physicians' Self-assessment in Intercultural Clinical Communication in Jeddah, Saudi Arabia: A Pilot Study

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To cite this article: Hani Atwa, Asmaa Abdel Nasser. Physicians' self-assessment in intercultural clinical communication in Jeddah, Saudi Arabia: a pilot study. Education in Medicine Journal. 2016;8(2):15-26. DOI: 10.5959/eimj.v8i2.420

To link to this article: http://dx.doi.org/10.5959/eimj.v8i2.420

ABSTRACT

Background: Physicians working with multicultural populations need to know how to determine the patients understanding of their illness. Physician working in Saudi Arabia must be aware of the diverse cultural and linguistic properties of people living there. They need to know how language and culture can influence clinical communication with patients and the way they provide them care. **Aim:** This study aims to explore physicians' self-assessment in intercultural communication in relation to care for patients from diverse ethnic/cultural backgrounds in order to identify training needs of physicians. **Subjects and Methods:** A descriptive cross-sectional study using self-administered questionnaire filled in by 254 working physician in Jeddah, Kingdom of Saudi Arabia (KSA). A good internal consistency coefficient (Cronbach's alpha) of the questionnaire was obtained. Descriptive statistics were used and ANOVA has been employed for assessing statistical differences between groups. **Results:** Respondents rated themselves more competent in basic clinical skills with mean score 4.33±0.58, then general intercultural skills came next (3.89±0.69) followed lastly by intercultural communication skills (3.29±1.00). Regarding intercultural communication skills and general intercultural skills, we found statistically significant differences ($p < 0.05$) in mean scores between respondents with reference to their age group, rank, total duration of work in KSA, previous work experience in other countries than home country and exposure to training in cultural competence. **Conclusion:** Training in cultural competence is an important factor that leads to better self-rating in intercultural communication skills. Physicians should be provided with real opportunities for training in cultural competence.

Keywords: *Intercultural communication, Cultural competence, Basic clinical skills*

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Introduction

Intercultural communication is often defined as "communication between people from different national cultures" (1). Many scholars limit intercultural communication to face-to-face communication (2).

The relationship between the patient and the health care provider is an essential component of the delivery of health care (3). One of the important issues in the study of this relationship is the relation between patients' ethnic/cultural background and medical communication. The fundamental question raised in this regard is to what

extent belonging to an ethnic/cultural group influences the communication process between patients and their doctors (4).

If you are working, or going to work, as a physician in the Kingdom of Saudi Arabia, you must be aware of the diverse cultural and linguistic properties of people living there. You will need to know how language and culture can influence your clinical communication with patients and the way you provide care for them, and to have the skills necessary to identify and respond efficiently to patients' diverse needs (5, 6).

Residents of the Kingdom of Saudi Arabia (KSA) are either native Saudis (66% of the whole population) or non-Saudis from different nationalities and ethnic/cultural backgrounds (34% of the whole population) (7). This roughly means that one of each three persons seeking medical care is non-Saudi, who may speak a different language and have come from a different cultural background. In addition, the majority of the physicians are non-Saudis (76% of practicing physicians) (8). These facts mandate the readiness of physicians to deal effectively with such differences.

Skills of dealing with such multicultural and multilingual patients include (beside the general basic clinical skills) the ability to elicit the patient's understanding of the illness, determine the patient's sociocultural context and identify any issues that might affect care, communicate effectively across patient-provider social and cultural differences, and providing information including giving bad news (9–11).

This study aimed at exploring the physicians' self-assessment in relation to care for patients from diverse ethnic/cultural and linguistic backgrounds in order to identify training needs of physicians.

Subjects and Methods

The study is a descriptive cross-sectional one. Based on a study by Hudelson et al. (12) and the number of practicing physicians in Jeddah, a sample size of 330 physicians was calculated. As it was difficult to obtain lists of practicing physicians in Jeddah and their contact details, we personally approached the indicated number of physicians in different governmental and private hospitals and health dispensaries all over the regions of central Jeddah. Data collection extended over around 4 months and the response rate was 77% (254; 175 males and 79 females).

We used the questionnaire developed by Hudelson et al. (13). Out of the 14 items of the original questionnaire, one item has been removed; which is "Explore the migratory trajectory and possible traumatic experiences of an asylum seeker". This is because it does not apply to the Saudi context. The 'modified' version of the questionnaire is composed of 13 items in three domains: Basic Clinical Skills (6 items), Intercultural Communication Skills (3 items), and General Intercultural Skills (4 items).

Internal consistency coefficients Cronbach's alpha coefficients) of the different subscales of the questionnaire, as well as the questionnaire as a whole, were obtained (Table 1). Based on the self-administered questionnaire, respondents were asked to rate themselves regarding their perceived competency in different skills pertaining to the three subscales of the questionnaire by choosing a number from 1 to 5 on the 5-point scale, where 5 means "Most Competent" and 1 means "Least Competent". Data were collected and entered to Microsoft Excel 2010. IBM SPSS v. 20 (14) was used for statistical analysis.

Data Analysis

Means and standard deviations (M±SD) has been calculated for each skill and for the three categories of skills (Basic Clinical Skills, Intercultural Communication Skills, and General Intercultural Skills). For differences between groups, we used analysis of variance (ANOVA) tests. Linear trends were applied for ordinal variables (Age Group, Rank and Total Duration of Work in KSA) and presented as line graphs. Statistical significance was set at $p < 0.05$.

Results

An overall number of 254 respondents were included in the study; 68.9% were males and 31.1% were females. Internal consistency was established through Cronbach's alpha coefficient. Table 1 shows good values for internal consistency for each of the questionnaire's subscales. Alpha values ranged from 0.629 for "Intercultural Communication Skills" to 0.806 for "Basic Clinical Skills".

Table 2 shows demographic characteristics of the studied sample. However, it was notable that most of the respondents were non-Saudi (70.9% non-Saudi Arabic, and 23.2% non-Saudi non-Arabic).

In addition, only a small percentage of the respondents (16.9%) reported that they had previous work experience outside their home countries before coming to Saudi Arabia. Also, a very small percentage (8.7%) reported that they have been exposed to any training in cultural competence.

Table 3 shows that, in general, basic clinical skills had a greater mean score (4.33±0.58) than the other two types of skills. General intercultural skills came next (3.89±0.69) followed lastly by intercultural communication skills (3.29±1.00).

Differences in mean scores of self-assessment scales in basic clinical skills were found to be statistically significant ($p < 0.05$) between respondents as regards age group, rank, total duration in KSA and current workplace (Table 4). In reference to nationality, gender, previous work experience in other countries than home country and exposure to training in cultural competence, differences in mean scores of self-assessment scales in basic clinical skills between respondents were found close with no statistical significance.

Table 1: Internal consistency study of the questionnaire using Cronbach's alpha

Subscales	Cronbach's alpha
Basic Clinical Skills	0.806
Intercultural Communication Skills	0.629
General Intercultural Skills	0.713

Regarding intercultural communication skills (Table 5) and general intercultural skills (Table 6), we found statistically significant differences ($p < 0.05$) in mean scores between respondents with reference to their age group, rank, total duration of work in KSA, previous work experience in other countries than home country and exposure to training in cultural competence. In reference to nationality, gender and current workplace, differences in mean scores of self-assessment scales in intercultural communication skills between respondents were found statistically insignificant.

Mean scores for ordinal data of Age Group (Figure 1), Rank (Figure 2) and Total Duration of Work in KSA (Figure 3) shows linear trend, where the mean scores increase concomitantly with increase in age, progress in rank from resident to consultant, and increase in the duration of work in KSA.

Discussion

Although our study aimed at evaluation of the physicians' self-assessment in intercultural communication skills, two other types of skills were also included in our study. Those skills were: basic clinical skills and general intercultural skills. This was because the three types of skills are strongly related. In addition, this was deemed to provide a comprehensive coverage of general skills (both clinical or communication skills) a physician is supposed to perform.

Among the three types of skills, physicians rated themselves best in basic clinical skills, especially in obtaining relevant medical history and performing targeted clinical examination. This was expected, as it touches the core competences of physicians and it is very uncommon that a physician assesses himself as weak in such competences. In addition, physicians are not allowed to practice in KSA until they pass the licensing exams of the Saudi Commission for Health Specialties (15). Similar results were found by Hudelson et al. (12). Also it is noticed that neither previous work experience in other countries nor training in cultural competence affected the self-assessment scores of physicians in their basic clinical skills.

Intercultural communication skills were rated least, especially for the skills of discussing religious preferences in relation to treatment and changing the beliefs of the patients who believe that their illness is due to supernatural causes. This may indicate a problem for the physicians in finding the best technique in convincing patients, may be due to inability to understand the patient's language or cultural backgrounds.

There were minor differences between male and female physicians in all the types of assessed skills. None of those differences was statistically significant; although it was reported by Roter and Hall (16) female clinicians tend to engage in more patient-centered communication.

Progress in age (from young physicians to older ones), in rank (from residents to consultants) and in the total duration of work in KSA were found to be associated with an increase in mean score for self-assessment in all the three types of skills. In addition, having previous work experience in other countries than home country was associated with an increase mean score both in intercultural communication skills and general intercultural skills. This indicates the importance of experience and practice in the progress of clinical skills, as well as in dealing with patients from different cultural and ethnic backgrounds (2, 17). However, other authors argued that experience alone without formal training in intercultural communication may negatively affect the attitude of physicians towards multicultural patients (18, 19).

In our study, exposure to training in cultural competence was found to cause significant differences in self-assessment mean scores for both intercultural communication skills and general intercultural skills. In their study on intercultural communication competence in family medicine, Rosenberg et al. (20) concluded that providing physicians with formal training in intercultural communication and empowerment training for patients is likely to improve the quality of care of immigrants. Hudelson et al. (12) found similar differences. However, the differences were statistically significant only for intercultural communication skills but not for general intercultural skills.

Although self-assessment is useful in giving an idea about the performance (21–23) and in determining self-confidence in intercultural situations (24–27), which is the case in our study, we cannot depend solely on self-assessment in assessing clinical and communication skills and other objective methods such as OSCE should be used (28, 29).

To the best of our current knowledge, there are no studies in intercultural clinical communication in the Arab region.

Table 2: Demographic characteristics of the studied sample

Groups	Demographics *(n=254)*	
	No.	**%**
Nationality:		
Saudi	15	5.9
Non-Saudi, Arabic	180	70.9
Non-Saudi, Non-Arabic	59	23.2
Gender:		
Male	175	68.9
Female	79	31.1
Age group:		
≤ 25 years	5	2.0
25–40 years	75	29.5
41–55 years	149	58.7
≥ 56 years	25	9.8
Rank:		
Resident	35	13.8
Specialist	99	39.0
Consultant	120	47.2
Total duration of work in KSA:		
≤ 1 year	17	6.7
2–5 years	101	39.8
6–10 years	100	39.4
> 10 years	36	14.2
Current workplace:		
Private	198	78.0
Governmental	56	22.0
Previous work experience in other countries than home country?		
Yes	43	16.9
No	211	83.1
Training in cultural competence?		
Yes	22	8.7
No	232	91.3

Table 3: Mean scores (and standard deviation) for each skill of the self-assessment questionnaire

Skills	Mean	SD
Basic Clinical Skills:	**4.33**	**0.58**
Obtain a medical history that is relevant to the patient's complaint.	4.95	0.46
Perform a clinical examination that is targeted at the patient's chief complaint.	4.93	0.76
Obtain a psychosocial history from the patient.	4.37	0.28
Announce bad news (e.g., an unfavorable prognosis).	3.47	0.77
Make sure that an illiterate patient understands the treatment of his chronic disease (e.g., hypertension, depression, etc.).	3.88	0.84
Explain the reason for refusing an unjustified treatment or investigation to patient who requests it.	4.35	0.39
Intercultural Communication Skills:	**3.29**	**0.69**
Discuss advantages and risks of unconventional therapies with a patient who uses them.	3.69	0.77
Discuss a patient's religious preferences and constraints regarding his treatment.	3.17	0.64
Communicate the importance of medical treatment to a patient who believes that his illness is due to supernatural causes.	3.02	0.67
General Intercultural Skills:	**3.89**	**1.00**
Work effectively with a professional interpreter.	3.91	1.05
Orient a foreign patient toward appropriate medical and social services.	3.85	0.76
Perform a physical examination of a Muslim woman who wears a veil.	3.57	1.19
Ask questions and give information to the husband of a patient, if she requests it.	4.22	1.01

Table 4: Mean scores and comparisons of self-assessment in basic clinical skills

Groups	Univariate Comparison	
	Mean (SD)	*p*-value
Nationality:		
Saudi	4.35 (0.43)	
Non-Saudi, Arabic	4.42 (0.62)	0.164
Non-Saudi, Non-Arabic	4.24 (0.70)	
Gender:		
Male	4.32 (0.62)	0.621
Female	4.36 (0.54)	
Age group:		
≤ 25 years	4.03 (0.57)	
25–40 years	4.15 (0.78)	0.001*
41–55 years	4.47 (0.55)	
≥ 56 years	4.55 (0.45)	
Rank:		
Resident	3.97 (0.53)	
Specialist	4.58 (0.58)	*0.000**
Consultant	4.52 (0.63)	

(*continued on next page*)

Table 4: (*continued*)

Groups	Univariate Comparison	
	Mean (SD)	*p-value*
Total duration of work in KSA:		
≤ 1 year	3.61 (0.42)	*0.000**
2–5 years	4.42 (0.57)	
6–10 years	4.54 (0.77)	
> 10 years	4.76 (0.59)	
Current workplace:		
Private	4.43 (0.52)	*0.023**
Governmental	4.24 (0.64)	
Previous work experience in other countries than home country?		
Yes	4.35 (0.50)	*0.634*
No	4.30 (0.65)	
Training in cultural competence?		
Yes	4.31 (0.54)	*0.824*
No	4.34 (0.61)	

Table 5: Mean scores and comparisons of self-assessment in intercultural communication skills

Groups	Univariate Comparison	
	Mean (SD)	*p*-value
Nationality:		
Saudi	3.31 (0.51)	*0.462*
Non-Saudi, Arabic	3.36 (0.74)	
Non-Saudi, Non-Arabic	3.22 (0.83)	
Gender:		
Male	3.28 (0.74)	*0.746*
Female	3.31 (0.64)	
Age group:		
≤ 25 years	3.06 (0.78)	*0.048**
25–40 years	3.15 (0.93)	
41–55 years	3.42 (0.65)	
≥ 56 years	3.45 (0.54)	
Rank:		
Resident	3.02 (0.63)	*0.006**
Specialist	3.45 (0.69)	
Consultant	3.43 (0.75)	
Total duration of work in KSA:		
≤ 1 year	2.74 (0.49)	*0.002**
2–5 years	3.36 (0.68)	
6–10 years	3.45 (0.92)	
> 10 years	3.62 (0.70)	
Current workplace:		
Private	3.37 (0.62)	*0.130*
Governmental	3.22 (0.76)	

(*continued on next page*)

Table 5: (*continued*)

Groups	Univariate Comparison	
	Mean (SD)	*p*-value
Previous work experience in other countries than home country?		
Yes	3.51 (0.48)	*0.001**
No	3.06 (0.89)	
Training in cultural competence?		
Yes	3.62 (0.63)	*0.000**
No	2.94 (0.74)	

Table 6: Mean scores and comparisons of self-assessment in general intercultural skills

Groups	Univariate Comparison	
	Mean (SD)	*p*-value
Nationality:		
Saudi	3.91 (0.74)	
Non-Saudi, Arabic	3.97 (1.07)	0.618
Non-Saudi, Non-Arabic	3.81 (1.21)	
Gender:		
Male	3.88 (1.07)	0.774
Female	3.92 (0.93)	
Age group:		
≤ 25 years	3.42 (0.98)	
25 – 40 years	3.53 (1.34)	0.000*
41 – 55 years	4.22 (0.95)	
≥ 56 years	4.29 (0.78)	
Rank:		
Resident	3.57 (0.91)	
Specialist	4.11 (1.00)	0.024*
Consultant	4.06 (1.09)	
Total duration of work in KSA:		
≤ 1 year	3.24 (0.72)	
2 – 5 years	3.97 (0.98)	0.014*
6 – 10 years	4.08 (1.33)	
> 10 years	4.28 (1.02)	
Current workplace:		
Private	3.98 (0.89)	0.233
Governmental	3.81 (1.10)	
Previous work experience in other countries than home country?		
Yes	4.17 (0.69)	0.007*
No	3.62 (1.29)	
Training in cultural competence?		
Yes	4.21 (0.91)	0.007*
No	3.57 (1.07)	

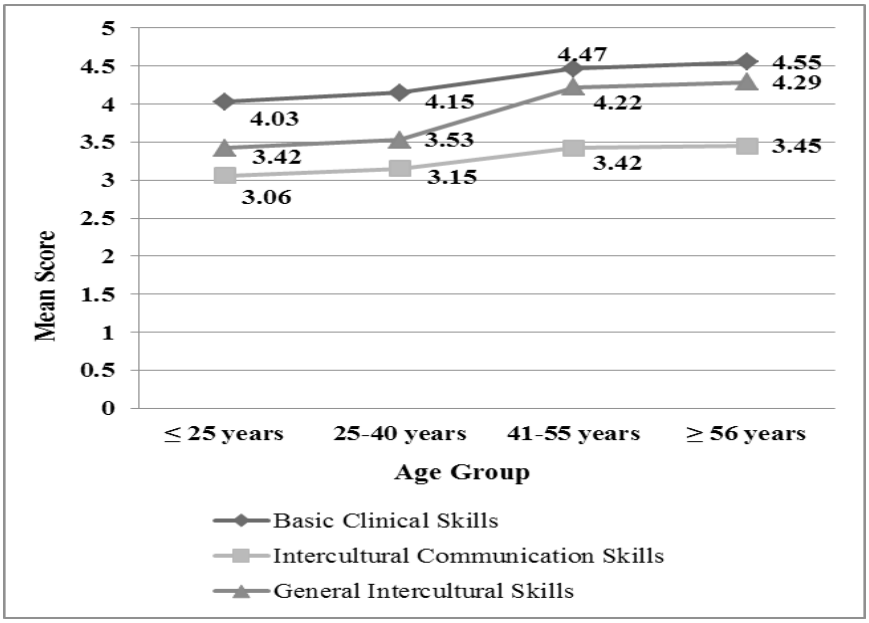

Figure 1: Linear trend of "Age Groups" variable

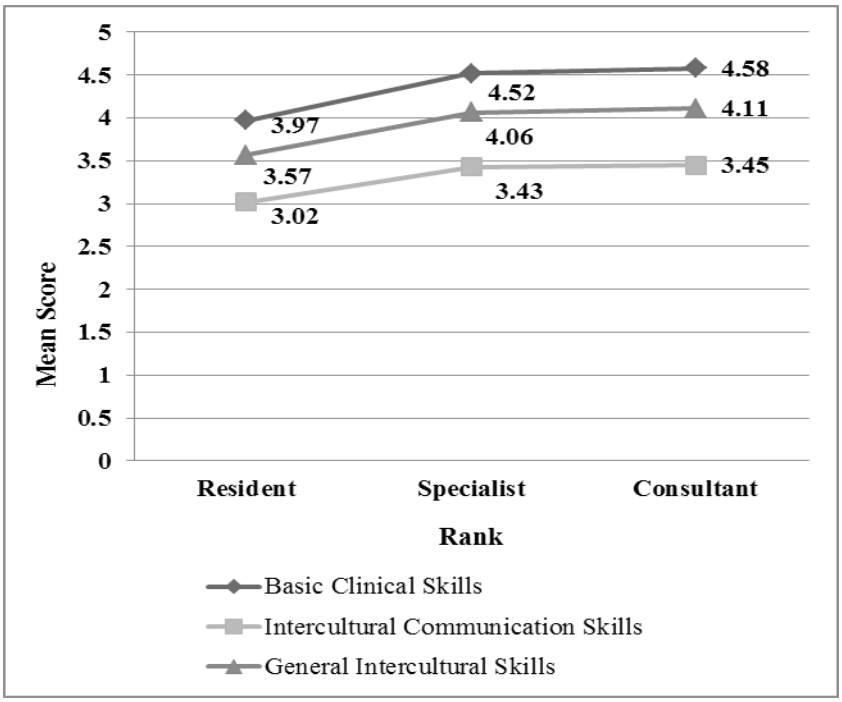

Figure 2: Linear trend of "Rank" variable

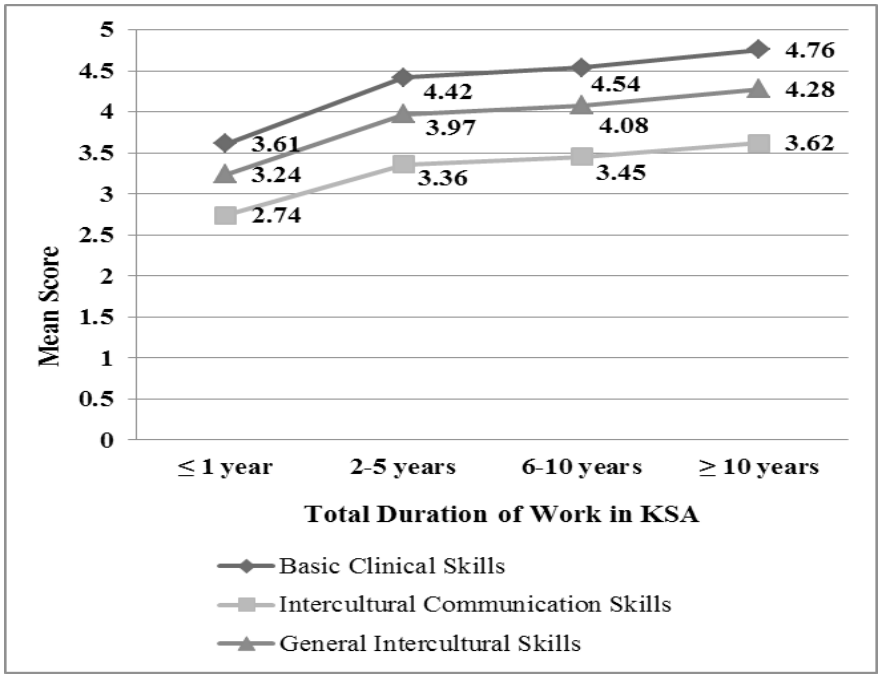

Figure 3: Linear trend of "Total Duration of Work in KSA" variable

Although this gave value to our study, we report that our study has some limitations, among which are: inadequate sampling and data collection techniques, restriction of the study to the region of Jeddah that may not be representative of all physicians in the Saudi health system and restriction of the study methods to self-assessment. We recommend addressing this important issue in a nation-wide, large scale study that uses different objective assessment methods of the intercultural communication competences in addition to self-assessment.

Conclusion

Training in cultural competence is among the important factors that lead to better self-rating in intercultural communication skills. Practicing physicians should not depend only on experience in gaining and improving their intercultural communication skills, but also they should be provided with real opportunities for training on such skills. That training should start formally while they are in the undergraduate stage at medical schools. Furthermore, as long as they are working with different patients from different cultural and national backgrounds, they should always seek opportunities for continuing professional development in this field.

Self-assessment in our study succeeded to give us an idea about performance of physicians in intercultural communication skills, but the assessment results can only be depended upon when mixed with objective methods of assessment of physicians in such skills.

Acknowledgements

We express our sincere thanks to the physicians who participated in the study.

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